FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042549

Facility Name: RIVER PARK HC CTR

Address: 2545 24th ST (Number) ROCK ISLAND (City) 61201 (Zip Code)

County: ROCK ISLAND

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4127168

Date of Initial License for Current Owners: 03/06/97

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,605	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,605	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,695		7,097	8,792	8
9	SNF/PED					9
10	ICF	35,792	6,767		42,559	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,487	6,767	7,097	51,351	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.48%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 7,097

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	171,191	18,603	7,856	197,650		197,650	3,714	201,364			1
2	Food Purchase		194,900		194,900	#REF!	#REF!	(2,640)	#REF!			2
3	Housekeeping	137,616	26,058		163,674		163,674		163,674			3
4	Laundry	60,834	12,072		72,906		72,906		72,906			4
5	Heat and Other Utilities			122,663	122,663		122,663	195	122,858			5
6	Maintenance	57,657	29,726	41,967	129,350		129,350	8,449	137,799			6
7	Other (specify):*			8,295	8,295		8,295		8,295			7
8	TOTAL General Services	427,298	281,359	180,781	889,438	#REF!	#REF!	9,718	#REF!			8
	B. Health Care and Programs											
9	Medical Director			16,842	16,842		16,842		16,842			9
10	Nursing and Medical Records	1,409,894	56,615	279,083	1,745,592		1,745,592	(247,218)	1,498,374			10
10a	Therapy	136,110	25,368	82,956	244,434		244,434	(7,334)	237,100			10a
11	Activities	81,618	6,568	819	89,005		89,005		89,005			11
12	Social Services	64,123		2,325	66,448		66,448		66,448			12
13	Nurse Aide Training											13
14	Program Transportation			64	64		64		64			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,691,745	88,551	382,089	2,162,385		2,162,385	(254,552)	1,907,833			16
	C. General Administration											
17	Administrative	86,917		126,000	212,917		212,917	(65,453)	147,464			17
18	Directors Fees											18
19	Professional Services			272,051	272,051		272,051	(219,377)	52,674			19
20	Dues, Fees, Subscriptions & Promotions			32,705	32,705		32,705	(3,409)	29,296			20
21	Clerical & General Office Expenses	127,449	14,489	145,803	287,741		287,741	(53,500)	234,241			21
22	Employee Benefits & Payroll Taxes			347,116	347,116	#REF!	#REF!		#REF!			22
23	Inservice Training & Education			2,387	2,387		2,387	817	3,204			23
24	Travel and Seminar			2,982	2,982		2,982	733	3,715			24
25	Other Admin. Staff Transportation			5,508	5,508		5,508	2,724	8,232			25
26	Insurance-Prop.Liab.Malpractice			149,106	149,106		149,106	2,841	151,947			26
27	Other (specify):*							40,324	40,324			27
28	TOTAL General Administration	214,366	14,489	1,083,658	1,312,513	#REF!	#REF!	(294,300)	#REF!			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,333,409	384,399	1,646,528	4,364,336	#REF!	#REF!	(539,134)	#REF!			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: RIVER PARK HC CTR **#0042549** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		656	
			0	7,856
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,349	
	ELECTRICITY		72,221	
	WATER		24,279	
	CABLE TV - LOBBY		2,814	
			0	122,663
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		2,529	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,443	
	ELEVATOR MAINTENANCE & REPAIR		13,860	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,590	
	FIRE SERVICE		10,545	
			0	
			0	
			0	41,967
7	**OTHER**			
	SCAVENGER		8,295	
	SECURITY SERVICE		0	8,295
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,842	16,842

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,409	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	550	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B 48-2	124	
	PSYCHIATRIC	XVIII B 47-2	50,000	
	RN CONSULTANT	XVIII B 38-2	0	
	MEDICARE & PUBLIC AID CONSULTANT		225,000	
			0	279,083
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		15,290	
	SPEECH THERAPY SERVICES		5,144	
	OCCUPATIONAL THERAPY SERVICES		12,227	
	THERAPY CONTRACT SERVICES		35,895	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	82,956
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	819	
			0	819
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,325	
			0	2,325
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number RIVER PARK HC CTR **#0042549** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		64	64
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	126,000	126,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,836	
	ADMINISTRATIVE CONSULTANTS	XIX C	210,000	
	PROFESSIONAL FEES	XIX C	40,215	
			0	272,051
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,402	
	EMPLOYEE WANT ADS	XIX F	12,918	
	CONTRIBUTIONS	VI 20 XIX F	100	
	DUES & SUBSCRIPTIONS	XIX F	9,649	
	LICENSES & PERMITS	XIX F	635	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	308	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	385	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,308	32,705
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		548	
	EQUIPMENT REPAIR & MAINTENANCE		3,352	
	OUTSIDE CLERICAL SERVICES		106,550	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,950	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,690	
	TELEPHONE		19,712	
	MESSENGER SERVICE		2,001	
			0	145,803

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	174,151	
	UNEMPLOYMENT COMPENSATION	XIX D	33,490	
	WORKERS COMPENSATION INSURANCI	XIX D	77,697	
	HOSPITALIZATION INSURANCE	XIX D	57,674	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,104	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	347,116
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,387	2,387
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	2,982	
			0	
			0	2,982
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,508	5,508
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		149,106	149,106
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,646,528

Facility Name & ID Number RIVER PARK HC CTR #0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,629	29,629		29,629	107,641	137,270			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,622	2,622		2,622	270,259	272,881			32
33	Real Estate Taxes			138,444	138,444		138,444		138,444			33
34	Rent-Facility & Grounds			497,307	497,307		497,307	(487,939)	9,368			34
35	Rent-Equipment & Vehicles			24,421	24,421		24,421	7,256	31,677			35
36	Other (specify):*											36
37	**TOTAL Ownership**			692,423	692,423		692,423	(102,783)	589,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		303,610	282,672	586,282		586,282	(50,515)	535,767			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,907	96,907		96,907		96,907			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		303,610	379,579	683,189		683,189	(50,515)	632,674			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,333,409	688,009	2,718,530	5,739,948	#REF!	#REF!	(692,432)	#REF!			45

#REF!

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,963)	30		9
10	Interest and Other Investment Income	(140,307)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,640)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(385)	20		17
18	Fines and Penalties	(11,950)	21		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,402)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(308)	20		28
29	Other-Attach Schedule	(27,862)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (210,917)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(481,515)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (481,515)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (692,432)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

RIVER PARK HC CTR

ID# 0042549

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 807	6	1
2	MARKETING SALARY	(28,669)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,862)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	3,714	0	0	0	0	0	0	0	0	0	3,714	1
2	Food Purchase	(2,640)	0	0	0	0	0	0	0	0	0	0	(2,640)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	195	0	0	0	0	0	0	0	0	0	195	5
6	Maintenance	807	7,642	0	0	0	0	0	0	0	0	0	8,449	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,833)	11,551	0	0	0	0	0	0	0	0	0	9,718	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(247,218)	0	0	0	0	0	0	0	0	0	(247,218)	10
10a	Therapy	0	7,491	0	(14,825)	0	0	0	0	0	0	0	(7,334)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(239,727)	0	(14,825)	0	0	0	0	0	0	0	(254,552)	16
	C. General Administration													
17	Administrative	0	(65,453)	0	0	0	0	0	0	0	0	0	(65,453)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(223,200)	0	3,823	0	0	0	0	0	0	0	(219,377)	19
20	Fees, Subscriptions & Promotions	(8,195)	0	0	4,786	0	0	0	0	0	0	0	(3,409)	20
21	Clerical & General Office Expenses	(40,619)	(106,200)	0	93,319	0	0	0	0	0	0	0	(53,500)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	817	0	0	0	0	0	0	0	817	23
24	Travel and Seminar	0	0	0	733	0	0	0	0	0	0	0	733	24
25	Other Admin. Staff Transportation	0	0	0	2,724	0	0	0	0	0	0	0	2,724	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,841	0	0	0	0	0	0	0	2,841	26
27	Other (specify):*	0	0	0	40,324	0	0	0	0	0	0	0	40,324	27
28	**TOTAL General Administration**	(48,814)	(394,853)	0	149,367	0	0	0	0	0	0	0	(294,300)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,647)	(623,029)	0	134,542	0	0	0	0	0	0	0	(539,134)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER PARK HC CTR # 0042549 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,963)	0	0	127,604	0	0	0	0	0	0	0	107,641	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(140,307)	0	0	410,566	0	0	0	0	0	0	0	270,259	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(487,939)	0	0	0	0	0	0	0	(487,939)	34
35	Rent-Equipment & Vehicles	0	0	0	7,256	0	0	0	0	0	0	0	7,256	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(160,270)	0	0	57,487	0	0	0	0	0	0	0	(102,783)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(50,515)	0	0	0	0	0	0	0	(50,515)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(50,515)	0	0	0	0	0	0	0	(50,515)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(210,917)	(623,029)	0	141,514	0	0	0	0	0	0	0	(692,432)	45

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY
				RIVER PARK HEALTHCARE CENTER LLC		
					NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 126,000	CAREPLUS MGMT INC		$	$ (126,000)	1
2	V	19	ADMIN. CONSULTANT FEES	210,000	" "			(210,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	106,200	" "			(106,200)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	10	M/C,PA,PSYCH FEES	275,000	" "			(275,000)	6
7	V	1	DIETARY SALARIES		" "		10,914	10,914	7
8	V	5	ELECTRICITY		" "		195	195	8
9	V	6	REPAIRS		" "		334	334	9
10	V	6	MAINTENANCE SALARIES		" "		7,308	7,308	10
11	V	10	NURSING		" "		27,782	27,782	11
12	V	10a	THERAPY SALARIES		" "		7,491	7,491	12
13	V	17	ADMIN SALARIES		" "		60,547	60,547	13
14	Total			$ 737,600			$ 114,571	$ * (623,029)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CAREPLUS MGMT INC		$ 3,823	$ 3,823	15
16	V	20	DUES/LICENSES/WANT ADS		" "		4,786	4,786	16
17	V	21	OFFICE SALARIES/EXPENSES		" "		93,319	93,319	17
18	V	23	SEMINARS		" "		817	817	18
19	V	24	TRAVEL		" "		733	733	19
20	V	25	TRANSPORTATION		" "		2,724	2,724	20
21	V	26	INSURANCE		" "		2,841	2,841	21
22	V	27	EMPLOYEE BENEFITS		" "		40,324	40,324	22
23	V	30	SL DEPRECIATION		" "		10,997	10,997	23
24	V	32	INTEREST		" "		42,731	42,731	24
25	V	34	OFFICE RENT		" "		9,368	9,368	25
26	V	35	EQUIP RENT/AUTO LEASE		" "		7,256	7,256	26
27	V								27
28	V								28
29	V								29
30	V	10a	THERAPY SERVICES	82,954	CAREPLUS REHABILITATIVE SERVICES		68,129	(14,825)	30
31	V	39	ANCILLARY THERAPY	282,671	" "		232,156	(50,515)	31
32	V								32
33	V								33
34	V								34
35	V	34	RENT	497,307	RIVER PARK HEALTHCARE CENTER LLC			(497,307)	35
36	V	30	SL DEPRECIATION		" "		116,607	116,607	36
37	V	32	INTEREST		" "		367,835	367,835	37
38	V								38
39	Total			$ 862,932			$ 1,004,446	$ * 141,514	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	5.4	9.03	SALARY	16,699	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	5.4	9.03	" "	16,699	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	5.4	9.03	" "	12,079	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	5.4	9.03	" "	12,618	21-7	5
6	BARAK BAVER	OFFICE MANAGER	CLERICAL	0.56	" "	5.4	9.03	" "	6,339	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 64,434		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,761	9 FACILITIES	$ 96,016	$ 10,914	51,351	$ 10,914	1
2	5	ELECTRICITY	" "	568,908	13 FACILITIES	2,165		51,351	195	2
3	6	REPAIRS	" "	568,908	13 FACILITIES	3,701		51,351	334	3
4	6	MAINTENANCE SALARIES	" "	568,908	13 FACILITIES	80,966	80,966	51,351	7,308	4
5	10	NURSING	" "	568,908	13 FACILITIES	307,794	307,794	51,351	27,782	5
6	10a	THERAPY SALARIES	" "	568,908	13 FACILITIES	82,996	82,996	51,351	7,491	6
7	17	ADMIN SALARIES	" "	568,908	13 FACILITIES	670,787	670,787	51,351	60,547	7
8	19	PROFESSIONAL FEES	" "	568,908	13 FACILITIES	42,352		51,351	3,823	8
9	20	DUES/LICENSES/WANT ADS	" "	568,908	13 FACILITIES	53,021		51,351	4,786	9
10	21	OFFICE SALARIES/EXPENSES	" "	568,908	13 FACILITIES	1,033,863	768,069	51,351	93,319	10
11	23	SEMINARS	" "	568,908	13 FACILITIES	9,053		51,351	817	11
12	24	TRAVEL	" "	568,908	13 FACILITIES	8,124		51,351	733	12
13	25	TRANSPORTATION	" "	568,908	13 FACILITIES	30,176		51,351	2,724	13
14	26	INSURANCE	" "	568,908	13 FACILITIES	31,470		51,351	2,841	14
15	27	EMPLOYEE BENEFITS	" "	568,908	13 FACILITIES	446,737		51,351	40,324	15
16	30	SL DEPRECIATION	" "	568,908	13 FACILITIES	121,842		51,351	10,997	16
17	32	INTEREST	" "	568,908	13 FACILITIES	473,414		51,351	42,731	17
18	34	OFFICE RENT	" "	568,908	13 FACILITIES	103,790		51,351	9,368	18
19	35	EQUIP RENT/AUTO LEASE	" "	568,908	13 FACILITIES	80,391		51,351	7,256	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,678,658	$ 1,921,526		$ 334,290	25

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC						$	$			$	1
2	CIB BANK		X	CAPITAL IMPROVEMENTS	$5,687.22	02/01	270,000	58,543	02/06	PRIME+	12,074	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	02/01	1,350	585			270	3
4	CIB BANK		X	MORTGAGE&LOAN COSTS	$42,224.00	12/98	5,100,000		12/04	7.7500	345,662	4
5	CAMBRIDGE		X	MORTGAGE			5,141,900	5,141,900	10/33		9,427	5
	Working Capital											
6	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	96,537	96,135			402	6
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC										42,731	7
8	INSURANCE FINANCING		X	INSUR. FINANCE							2,622	8
9	TOTAL Facility Related				$47,911.22		$ 10,609,787	$ 5,297,163			$ 413,188	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,609,787	$ 5,297,163			$ 413,188	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 129,640	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 133,374	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,734	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 134,710	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 138,444	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	120,575	8
	1999	120,444	9
	2000	122,973	10
	2001	128,360	11
	2002	133,374	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER PARK HC CTR COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0042549

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-341-78-00	NURSING HOME	$ 132,198.24	$ 132,198.24
2.	10-341-79-00	NURSING HOME	$ 1,175.56	$ 1,175.56
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,373.80	$ 133,373.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:RIVER PARK HEALTHCARE CENTER LLC			$	1
2	NURSING HOME: 5.16 ACRES		1997	420,000	2
3	TOTALS			$ 420,000	3

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC:				$	$		$	$	$	4
5	177		1997	1975	3,596,265	92,208	39	92,208		580,185	5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING,WALLCOVER,WINDOW TREATMENTS,DOORS			1997	66,202	1,698	39	1,698		11,271	9
10	WINDOWS			1998	2,278	58	39	58		317	10
11	WALK-IN FREEZER COMPRESSOR			2000	2,097	76	27.5	76		295	11
12	ELECTRICAL WORK			2001	1,854	67	27.5	67		182	12
13	NEW GREASE TRAP & CHANGEOUT WATER HEATER			2002	10,887	396	27.5	396		423	13
14	DOORS / CABLE INSTALLATION			2003	5,954	21	27.5	21		21	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					106		106			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,685,537	$ 94,630		$ 94,630	$	$ 592,694	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 212,755	$ 26,716	$ 17,099	$ (9,617)	8-15 YRS	$ 74,526	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 10,891 / RIVER PARK LLC, 22,500		33,391	22,291	(11,100)			74
75	TOTALS	$ 212,755	$ 60,107	$ 39,390	$ (20,717)		$ 74,526	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN		2001	$ 13,000	$ 2,496	$ 3,250	$ 754	4 YRS	$ 8,125	76
77										77
78										78
79										79
80	TOTALS			$ 13,000	$ 2,496	$ 3,250	$ 754		$ 8,125	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,331,292	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 157,233	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,270	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,963)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 675,345	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 24,421 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 105,813	$		$ 105,813	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,547			25,547	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			129,756			129,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				191,627		191,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3				21,556	90,672		112,228	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					21,311		21,311	13
14	TOTAL			$		$ 282,672	$ 303,610		$ 586,282	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,547,465		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,257,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	151,719		7
8	Accounts Receivable (owners or related parties)	67,810		8
9	Other(specify): R.E,TAX ESCROW	11,672		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,035,666	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,787		15
16	Equipment, at Historical Cost	225,755		16
17	Accumulated Depreciation (book methods)	(177,080)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 50,462	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,086,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 864,053	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,478		31
32	Accrued Real Estate Taxes(Sch.IX-B)	134,710		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,119,740	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	146,421		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 146,421	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,266,161	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,819,967	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,086,128	$	48

***(See instructions.)**

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,194,784	1
2	Restatements (describe):		2
3	2002 IL REPLACEMENT TAX	(8,638)	3
4	ROUNDING	8	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,186,154	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	633,813	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 633,813	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,819,967	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,201,102	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,201,102	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	36,380	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 36,380	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	140,307	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 140,307	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,377,789	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	889,438	31
32	Health Care	2,162,385	32
33	General Administration	1,312,513	33
	B. Capital Expense		
34	Ownership	692,423	34
	C. Ancillary Expense		
35	Special Cost Centers	586,282	35
36	Provider Participation Fee	96,907	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	4,028	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,743,976	40
41	**Income before Income Taxes (line 30 minus line 40)****	633,813	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 633,813	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,048	4,379	$ 106,535	$ 24.33	1
2	Assistant Director of Nursing	1,699	1,707	34,037	19.94	2
3	Registered Nurses	4,430	4,571	86,385	18.90	3
4	Licensed Practical Nurses	32,973	34,752	534,492	15.38	4
5	Nurse Aides & Orderlies	66,822	67,545	624,115	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,833	1,915	37,336	19.50	7
8	Rehab/Therapy Aides	9,407	10,120	98,774	9.76	8
9	Activity Director	1,966	2,175	23,769	10.93	9
10	Activity Assistants	5,945	6,596	57,849	8.77	10
11	Social Service Workers	3,625	4,132	64,123	15.52	11
12	Dietician					12
13	Food Service Supervisor	2,012	2,149	32,659	15.20	13
14	Head Cook	8,747	9,642	77,326	8.02	14
15	Cook Helpers/Assistants	9,260	9,504	61,206	6.44	15
16	Dishwashers					16
17	Maintenance Workers	4,964	5,236	57,657	11.01	17
18	Housekeepers	16,567	17,832	137,616	7.72	18
19	Laundry	7,829	8,368	60,834	7.27	19
20	Administrator	2,169	2,385	71,605	30.02	20
21	Assistant Administrator	796	796	15,312	19.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,798	7,466	98,780	13.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,085	2,317	24,330	10.50	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,994	2,149	28,669	13.34	33
34	TOTAL (lines 1 - 33)	195,969	205,736	$ 2,333,409 *	$ 11.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	16,842	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	819	11-3	44
45	Social Service Consultant	E	2,325	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		50,000	10-3	47
48	PHYSICIANS		124	10-3	48
49	TOTAL (lines 35 - 48)		$ 92,260		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRIS WELCH	ADMIN	0	$ 71,605
TAMARA STONEBERGER	ASST ADMIN	0	9,936
DAWN MAY	ASST ADMIN	0	5,376
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,917

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 126,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 126,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 13,200
CAREPLUS MGMT	ADMIN CONSULT	210,000
AMERICAN DATA	DATA PROC	2,427
NATIONAL DATACARE	DATA PROC	2,981
ACHIEVE	DATA PROC	3,228
MEYER MAGENCE	LEGAL	1,118
HAMLIN & BURTON	LEGAL	422
PERSONNEL PLANNERS	UNEMPL CONSULT	1,725
KBKB	ACCT	31,100
RICHARD PEELO	M/C COST REPORT	5,850
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 272,051

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 77,697
Unemployment Compensation Insurance		33,490
FICA Taxes		174,151
Employee Health Insurance		57,674
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,104
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,918
Health Care Worker Background Check	1,308
(Indicate # of checks performed 72)	
MARKETING/ADV/PROMO	7,710
TRUST/FRANCHISE/CONTRIB/ETC	485
LICENSES & PERMITS	635
DUES & SUBSCRIPTIONS	9,649
MGMT CO ALLOCATION	4,786
TRUST/FRANCHISE/CONTRIB/ETC	(485)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,402)
Yellow page advertising	(308)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,296

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	2,982
MGMT CO ALLOCATION	733
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,715

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2001	$ 2,062	3	$	$ 344	$ 687	$ 687	$ 344	$	$	$	$
2	PAINT/DECORATING	2002	6,681	3			1,114	2,227	2,227	1,113			
3	PAINT/DECORATING	2003	2,529	3				422	843	843	421		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
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20	TOTALS		$ 11,272		$	$ 344	$ 1,801	$ 3,336	$ 3,414	$ 1,956	$ 421	$	$

Facility Name & ID Number RIVER PARK HC CTR # 0042549 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $9,558**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **722** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,907**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees